Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: NORTHWEST TEXAS HOSPITAL 3255 WEST PIONEER PARKWAY ARLINGTON TEXAS 76013-9633	MFDR Tracking #:	M4-08-7231-01
Respondent Name and Box #: Zurich American Insurance Company Box #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "MAR for 73610 is $46.21 x 140% = $64.65. Insurance is $40.69 short."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $40.69
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…This is a medical fee dispute regarding x-rays billed for service date 12/15/2007. These services appear to be for an emergency room evaluation and not an outpatient surgical treatment. Pursuant to 28 TAC 134.401(a)(3), radiographic studies are not covered by the Medicare–based fee guideline and are reimbursed based upon a 'fair and reasonable' standard. Carrier asserts that its reimbursement constitutes a fair and reasonable payment to the facility for a three-view x-ray of the ankle. The normal Medicare facility fee MAR is $26.98…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/15/2007	150, 850-243, 900-030, 900-068, 920-002, W4	Emergency Room Visit	$40.69	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 150—"Payer deems the information submitted does not support this level of service."
   - 150—"Payer deems the information submitted does not support this level of service. $24.00"

- 850-243—"CV: The recommended allowance reflects a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria ser forth in Section 413.011(d) of the Texas Workers Compensation Act. M-No MAR $24.00."
- 900-030—"CV: This charge was reviewed through the clinical validation program."
- 900-068—"CV: Additional reconsideration of this bill and submitted documentation does not support additional payment. Recommended final allowance."
- 920-002—"In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance."
- W4—"No additional reimbursement allowed after review of appeal/reconsideration."
- Bill Notes—"charges for the facility in which the provider elected to have procedures or surgery performed on an outpatient basis are paid at a fair and reasonable amount pursuant to the criteria set forth in Section 413.011(b) of the Texas Workers' Compensation Act."

2. This dispute relates to outpatient emergency services with diagnostic radiological studies provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401 (a)(3) and (a)(5), effective August 1, 1997, 22 TexReg 6264, which provide that such services shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.
3. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… This request for medical fee dispute resolution was received by the Division on June 24, 2008. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue"…This request for medical fee dispute resolution was received by the Division on June 24, 2008. Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).
7. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Division rule at 28 TAC §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"… The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "MAR for 73610 is $46.21 x 140% = $64.69." Review of the submitted documentation finds that the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 Texas Labor Code §134.1. The request for additional reimbursement is not supported. The

Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 Texas Labor Code §133.307(c)(2)(G). Reimbursement cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Divisions rules at 28 Texas Administrative Code §133.307 (c)(2)(f)(iii), §133.307 (c)(2)(f)(iv) and §133.307 (c)(2)(g). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	November 12, 2009 Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.